Blueprint Counseling

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BEHAVIORAL HEALTH REFERRAL & WRITTEN SERVICE ORDER

General Referral Form | NC Medicaid Service Order, when applicable

1. CLIENT INFORMATION

Client First Name:	**Client Last Name:**
Date of Birth: _	**Age:** Gender: ☐ Male ☐ Female ☐ Other/Prefer not to say
Client Address:	**City / State / ZIP:**
Medicaid / Insurance ID:	**Date of Referral:**

2. PARENT / LEGAL GUARDIAN INFORMATION, IF APPLICABLE

Parent / Legal Guardian:	**Relationship:**
Home Phone:	**Cell Phone:** OK to leave message? ☐ Yes ☐ No
Client / Guardian Email:	**Preferred Contact:** ☐ Phone ☐ Text ☐ Email

3. REFERRAL SOURCE / ORDERING PROVIDER

Complete the referral source information for all referrals. Complete the ordering provider fields and signature when this form is being used as a written service order.

Contact / Provider Name:	**Agency / Practice:**
Office Phone:	**Fax / Cell:**
Email:	**NPI, if applicable:**

Referral / Order Type: ☐ General behavioral health referral ☐ Written service order for NC Medicaid services provided by an associate

4. SERVICES REQUESTED

Requested Service: ☐ Individual Outpatient Therapy ☐ Family Therapy ☐ Other:

Frequency: Based on clinical need **Duration:** Based on clinical need **Number of Sessions:** Based on clinical need
Anticipated Start Date of Services:

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5. DIAGNOSIS OR PRESENTING CONCERNS

Provide a diagnosis or, if no diagnosis has been made, list the client's presenting concerns.

Diagnosis, if known: _ **ICD-10 Code(s), if applicable:**

Presenting concerns, symptoms, behaviors, functional impairment, or other reason for referral:

6. ORDERING PROVIDER CERTIFICATION, IF USED AS A WRITTEN SERVICE ORDER

To support timely scheduling and clinician placement, Blueprint Counseling requests that qualified referring providers complete this section for all clients. **A written service order is required prior when a Medicaid beneficiary is assigned to an associate-level clinician.** Blueprint Counseling determines clinician-client matches based on clinical need, provider qualifications, and availability.

I certify that I am ordering the behavioral health services identified on this form based on the client's behavioral health needs and clinical presentation.

Ordering Provider Credentials: ☐ MD/DO ☐ Licensed Psychologist (Doctoral Level) ☐ Nurse Practitioner (NP) ☐ Physician Assistant (PA)

Ordering Provider Name:	**NPI:**
Provider Phone:	**Provider Fax:**
Provider Signature:	**Date Signed:**

7. SERVICE ORDER PARAMETERS

Services may be provided based on clinical need, treatment progress, and medical necessity. Frequency, duration, and number of sessions may vary based on the client's clinical need.

8. FOR BLUEPRINT COUNSELING USE

Clinician Assigned:	**Date Received:**
Received By:	**Order Reviewed By:**
Date Reviewed:	**Intake / Follow-up Date:**
Order placed in client record: ☐ Yes ☐ No	**Referral Status:** ☐ Accepted ☐ Pending ☐ Other:

SUBMIT COMPLETED FORM

Email is preferred, but we have an option to fax for your convenience.

Email: info@myblueprintcounseling.com | Fax: 336.646.6726 (email is preferred)

Blueprint Counseling will contact the client or parent/legal guardian for additional information and, when appropriate, schedule an intake assessment.